QUESTIONNAIRE FOR SPECIALIZED WOUND THERAPY

INDIVIDUAL ANSWERS TO ALL OF THE QUESTIONS ARE REQUIRED FOR CONSIDERATION OF SPECIALIZED WOUND THERAPY. ATTACH ADDITIONAL SHEETS IF NECESSARY. IF A QUESTION DOES NOT APPLY, PLEASE MARK IT NOT APPLICABLE.

IF THE PATIENT HAS MORE THAN ONE WOUND FOR WHICH TREATMENT IS BEING RQUESTED, COMPLETE A SEPARATE FORM FOR EACH WOUND.

PATIENT INFORMATION

Name: _____ DOB: _____ Recipient ID: _____

Address: _____ Phone #: _____

Patient Living Arrangements: _____ Home alone Medicare A_____ B_____
_____ Home with a caregiver
_____ Supported Living Facility
_____ Long Term Care Facility with Admission Sheet

WOUND INFORMATION

Surgery Date: _____

Wound Type: _____ Age of Wound: _____

Location: _____ Measurements (in cm.): _____
Length Width Depth

Tunneling or undermining? _____Yes _____No Infected? _____Yes _____No

Drainage? _____Yes _____No

If Yes, describe amount and type of drainage: _____

Describe the history of the wound. Include all previous therapies tried, and the response (if any) to those therapies: _____

_____

_____

PATIENT'S GENERAL HEALTH STATUS

Patient Height: _____ Weight: _____

Comorbid conditions or complications to healing: _____

_____

General nutritional status: ___Good ___Fair ___Poor Appetite: ___Good ___Fair ___Poor

Patient compliance with treatment regimens: ___Good ___Fair ___Poor

TREATMENT WILL BE OVERSEEN OR ADMINISTERED BY:

Home Health Agency: _____ HFS Provider #: _____

HHA Contact Person: _____ Phone #: _____

If care will be overseen by a representative of the equipment manufacturer, please provide that person's name and phone number: _____

If therapy will be administered by other than a Home Health Agency, please provide the name and phone number of the individual or entity. Describe the relationship, and any specialized training this individual has received or will receive.

_____

_____

_____

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY

Patient Name: _____ Diagnosis: _____

Therapy ordered and complete treatment regimen: _____

_____

Anticipated duration of therapy: _____

Goal of wound therapy: ___Complete healing ___Prep for surgical closure ___Prep for surgical graft

Date patient last seen: _____

Physician's personal observation of the wound agrees with above description? ___Yes ___No

Describe any other considerations that may affect the therapy, including anticipated patient compliance: _____

_____

_____

NOTE: Initial approvals and the first extension will be for no more than 30 days each. Renewals or extensions beyond the first 60 days require a progress report, based on the physician's personal observation of the wound.

Physician Name: _____

Address: _____

Phone #: _____

Physician Signature: _____

Date: _____